PRINTED: 10/14/2010 FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS5643AGC 06/25/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6130 EISNER DRIVE **LUDY'S HOME LIVING 4 - RESORT** LAS VEGAS, NV 89131 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 6/24/10 through 6/25/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons, Category I and II residents. The census at the time of the survey was six. Six resident files were reviewed and five employee files were reviewed. One discharged resident file was reviewed. The facility received the grade of A. The following deficiencies were identified: Y 072 Y 072 449.196(3) Qualifications of Caregiver-Med SS=D Training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training

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Severity: 2 Scope: 2

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Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS5643AGC 06/25/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6130 EISNER DRIVE **LUDY'S HOME LIVING 4 - RESORT** LAS VEGAS, NV 89131 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 106 Continued From page 2 Y 106 Y 106 449.200(2)(a) Personnel File - 1st aid & CPR Y 106 SS=D NAC 449.200 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1. (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation. This Regulation is not met as evidenced by: Based on record review on 6/24/10 through 6/25/10, the facility failed to provide evidence that 1 of 5 caregivers was trained in cardiopulmonary resuscitation (CPR) (Employee #2). Severity: 2 Scope: 1